

MCHIP Country Brief: Nigeria



Selected Health and Demographic Data for Nigeria	
Maternal mortality ratio (deaths/100,000 live births)	545
Neonatal mortality rate (deaths/1,000 live births)	40
Under-five mortality rate (deaths/1,000 live births)	128
Infant mortality rate (deaths/1,000 live births)	69
Modern contraceptive prevalence rate (%)	10%
Total fertility rate	5.5
Skilled birth attendant coverage	39%
Antenatal care, 4+ visits	44.8%

Sources: Nigeria 2008 Demographic and Health Survey; *World Bank 2011; **World Bank 2014.

Health Areas:

- Maternal Health
- Newborn Health
- Family Planning
- Immunization (Polio)



Program Dates	April 1, 2009–December 31, 2011					
Total Mission Funding	Redacted					
Geographic Coverage	No. (%) of states	8.3%	No. of districts	28 local government areas	No. of facilities	57
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INTRODUCTION

The 2008 Nigeria Demographic and Health Survey revealed that while Nigeria had made some progress in maternal, newborn, and child health indices, this progress was inadequate. These findings reinforced the opinion that Nigeria belonged to the group of countries making “insufficient” progress toward the attainment of Millennium Development Goals 4 and 5,¹ especially in the Northwest geopolitical zone of Nigeria. This zone has a particularly high maternal mortality ratio of 1,025 compared to the national average of 800 deaths per 100,000 live births.² Skilled attendance at birth, antenatal care attendance, and contraceptive prevalence rate were also very low in this zone while the total fertility rate was high. As outlined in the National Integrated Maternal, Newborn and Child Health (IMNCH) strategy and Midwifery Service Scheme (MSS), the government of Nigeria (GoN) is committed to improving health outcomes for pregnant women and their families.

The goal of the U.S. Agency for International Development’s (USAID’s) Maternal and Child Health Integrated Program (MCHIP) in Nigeria was to contribute to the reduction of maternal and neonatal mortality by achieving its life-of-project (LOP) objective of increased utilization of quality emergency obstetric and newborn care (EmONC) services by pregnant women, mothers, and their newborns in selected local government areas (LGAs) in three states—Kano, Zamfara, and Katsina. MCHIP was well-positioned to support the GoN to address MNCH interventions, drawing on technical and programmatic expertise from the previous ACCESS Nigeria program. MCHIP continued the implementation of the ACCESS Program’s integrated community- and facility-based essential maternal and newborn care interventions focusing on antenatal care (ANC), comprehensive and basic EmONC, postpartum care, and family planning for healthy timing and spacing of pregnancies using a household-to-hospital continuum of care (HHCC) approach.

KEY ACHIEVEMENTS

MCHIP advocated for supporting high-impact and evidence-based interventions as well as building the country’s capacity in MNCH and FP, working with the GoN. Thanks to a strong partnership with the GoN and other implementing partners and support from USAID, many achievements were observed throughout the duration of the project (see text box above).

Summary of Achievements

- Implemented evidence-based EmONC interventions in three states (representing 8.3% national coverage) in continuation of the ACCESS Program.
- Supported 57 health facilities in 28 local government areas (LGAs).
- Project-trained skilled birth attendants supervised 879,385 antenatal visits, 183,355 institutional deliveries, provided active management of third stage of labor to 156,498 women, used the partograph for 81,437 deliveries, and provided essential newborn care to 175,906 newborns seen within three days of birth.
- 449 trained male birth spacing motivators counseled and referred 11,371 men, of whom 28.3% accepted a family planning (FP) method for themselves or their spouses. The contraceptive prevalence rate for modern methods in the region is 2.5%.
- 477 trained female household counselors reached 32,926 women and referred 12,481 to health facilities.
- 2,919 members of 109 Mothers’ Savings and Loans Clubs that were established raised over **Redacted** to be used as loans for small-scale businesses or for health care.
- 352 health care workers were trained in the “Helping Babies Breathe” program and 60 NeoNatalie anatomic models were donated.
- Long-acting reversible contraception (LARC) services were provided to 466 women through FP outreaches.
- More than 20 videos on newborn care produced in partnership with Global Health Media Project (all now online through WHO’s Reproductive Health Library website).

¹ Countdown to 2015, 2008 Report.

² FMOH, 2000.



MCHIP supported and worked with a variety of maternal and child health/family planning/ reproductive health stakeholders to develop National Performance Standards for EmONC and FP, which led to an increase in the quality of care consciousness in the health sector. Additionally, the program advocated with other implementing partners for the creation of the Midwifery Service Scheme to increase the number of skilled birth attendants deployed throughout the country. Concurrently, MCHIP reviewed the pre-service midwifery curriculum in project states to ensure the inclusion of evidence-based EmONC and FP interventions.

MCHIP also participated in the Family Planning Action Group (FPAG), which successfully advocated for the GoN policy change in FP commodities in April 2011, making access to FP commodities free of charge. These are some of the many interventions that may have contributed to the reduction in Nigeria's maternal mortality.

In order to increase access and improve the quality of care, MCHIP trained 2,678 people on health-related subjects. Eighteen health centers were refurbished and basic obstetric equipment was donated. The skilled birth attendants from 57 facilities supervised 879,385 antenatal visits, 183,355 institutional deliveries, provided active management of third stage of labor (AMTSL) to 156,498 women, used the partograph for 81,437 deliveries, and provided essential newborn care to 175,906 newborns seen within three days of birth.³

The program also established 19 community mobilization teams to guide communities to prioritize maternal, newborn, and FP issues and to leverage additional resources (emergency transport and communication) and support from philanthropists and traditional/political leaders.⁴ Through 477 trained household counselors and 449 Male Birth-Spacing Motivators, the program was able to increase pregnant women's knowledge about danger signs in pregnancy and during and after childbirth, and inform couples about healthy timing and spacing of pregnancies and use of modern contraception.

After the end-of-project financial adjustments, available funds were used, at the request of USAID, to conduct a baseline assessment of the readiness of three states (Akwa Ibom, Benue, and Imo) on their readiness to provide basic and comprehensive EmONC to pregnant women and their newborns. This led to an assessment of 30 health facilities' infrastructure and human and material resources as well as knowledge and skills assessment of about 118 frontline health care workers. Details of the assessment findings are available in a separate report.⁵

In Immunization, MCHIP began a 2-phase research study to help inform national strategy on polio eradication. This study will help identify household factors affecting demand for polio vaccination and rates of missed children in northern Nigeria. MCHIP completed the first phase which consisted in data collection and the beginning of analysis. The second phase will continue in the follow-on project, MCSP.

³ MCHIP/Nigeria Routine Service statistics template.

⁴ MCHIP project report.

⁵ MCHIP Nigeria. Project Report: An Assessment of Health Facilities in Akwa Ibom, Benue and Imo States on Their Readiness to Provide Emergency Obstetric and Newborn Care.

WAY FORWARD

The MCHIP programs have demonstrated that the implementation of an HHCC approach consisting of a package of community and facility interventions can lead to increased knowledge of communities about maternal and newborn health issues and increased utilization of health facilities for maternal, newborn, and FP services. However, these efforts need to be sustained and scaled up statewide and nationally for the full impact of the interventions to meet the 2015 targets of the Millennium Development Goals. MCHIP leaves a legacy of competent frontline health workers to provide basic maternal and newborn services and empowered community mobilizers. All the training materials and job aids developed by MCHIP have been provided to the GoN at the national and county levels as well as to other implementing partners so they can continue to implement the program over the long term.

Some recommendations for the way forward include:

- Advocacy for the passage of the National Health Bill must be intensified. This bill has been in the national assembly for 8 years. When passed, it will provide approximately 2 percent of the national budget for primary health care and is intended to support the national health insurance scheme, procure essential drugs and medications, and renovate dilapidated PHC structures while developing the capacity of health care workers within the PHC system. If passed and implemented as designed, this will address the problem of under-funding of the PHC system in the country and reduce donor-dependency while bringing quality basic health care nearer the people.
- In the interim, the findings from this project and other similar projects which emphasize the importance of skilled attendance at birth should be disseminated widely at national and sub-national levels for replication. State Governments must take advantage of the MSS and SURE-P projects initiated by the Federal Government and replicate the positive lessons learnt in their states. By and large, this means establishing additional 'hospital-PHC clusters' and attracting nurse-midwives who will be deployed like in the MSS program. Thereafter and using the funds from the National Health Bill, build the capacity of frontline health care workers in PHCs to provide basic emergency obstetric and newborn care.
- Advocacy for the approval of the proposed Jhpiego supported and MacArthur funded National Task Shifting policy by the National Council on Health (NCH) to allow CHEWs to provide basic emergency obstetric and newborn care. In states with an acute shortage of midwives, community health extension workers (CHEWs) should be identified and trained to provide BEmONC. Hospitals that are attached to the MSS clusters should be made functional to provide comprehensive EmONC sites which will include Caesarean delivery, blood transfusion and anesthesia services.
- While the implementation of the SBM-R framework helped raise quality of care consciousness, the sheer number of set standards and numerous verification criteria has made SMB-R implementation highly human resource intensive. Therefore, the performance monitoring tools should be revised to significantly reduce the number of standards and verification criteria to a manageable number. For example, an expansion of WHO's new one-page Safe Birth Checklist will be a good starting point. The use of these tools should be tied to output indicators such as use of active management of the third stage of labor and use of magnesium sulphate.
- Future programs should assist States to implement the recently approved Maternal and Perinatal Death Reviews of the GoN.
- Critical interventions for the prevention and/or treatment of the common causes of maternal and newborn mortality should be prioritized for scale up. These should include the following:

- Scale-up of AMTSL, including use of misoprostol at home births to prevent PPH.
- Scale-up of the application of chlorhexidine at home and institutional births to prevent umbilical cord sepsis
- Scale-up of use of Magnesium Sulphate for the prevention and treatment of eclampsia. This will involve the enactment of the task-shifting or task-sharing policy that will allow CHEWs to provide these services at PHCs before referral to general hospitals.
- Use of the partograph to monitor active labor and to identify slow progress for intervention before adverse events like obstructed labor occur.
- Scale-up of essential newborn care and the 'Helping Babies Breathe' program with provision of infant Ambu bags and Penguin bulb syringes to all health facilities
- Scale-up of the use of MVA for evacuation of products of conception in unsafe abortion.
- Scale-up of appropriate infection prevention practices including use of parenteral antibiotics for treatment of puerperal and neonatal sepsis.
- Focused antenatal care which integrates malaria in pregnancy and PMTCT interventions should be scaled up to all LGAs in all the states.
- Education of the community about healthy timing and spacing of pregnancies (HTSP) and use of family planning to achieve this should be a priority. Promotion of exclusive breast feeding in the postpartum period which will assure lactational amenorrhea as a contraceptive method transitioning to long-acting methods after six months. Training of nurse/midwives and CHEWs to provide long-acting reversible contraception (LARC) will be a critical intervention for HTSP.
- States should map out existing community coalition groups and select volunteers to be trained as household counselors, male birth spacing motivators and community champions for maternal and newborn health care. These community groups should be empowered to leverage resources from within and outside the community to improve access to quality services. CBOs may be engaged to implement this arm of the HHCC framework given their integration in the community. A basket on incentives to retain trained community health volunteers should be designed and implemented.
- Efforts should be made to enforce GoN's new free FP commodity policy. In order to remove the often quoted excuses for continuation of formal and informal user fees, GoN should invest in the procurement of essential consumables for providing these contraceptive services e.g. gloves, lotions, gauze swabs, local anesthetics etc. Funds should also be provided for transporting the commodities out of the Federal Government's Central Medical Stores to State Medical Stores and eventually to the end user clinics. The release of funds committed by the GoN for FP during the 2012 FP2020 conference in London requires continuing advocacy to the FMOH, the Federal Ministry of Finance and the Appropriation Committee of the National Assembly.
- The findings from the MCHIP/MCSP Polio research, once available, should be utilized as part of a comprehensive review process to inform and operationalize timely strategic implementation for polio eradication.